

IN THE MATTER OF

MATTHEW CHORNEY, a member of the College of Paramedics of Manitoba (the “College”)

AND IN THE MATTER OF

A hearing of the Inquiry Committee Panel (the “Panel”) of the College pursuant to Part 8 of *The Regulated Health Professions Act, C.C.S.M., c. R117* (the “Act”)

Panel

Michael Foote (Chair/Public Representative)
Julie Braaksma (Member)
Deanna Douglas (Public Representative)
Amy Hancox (Member)
Cory Parrott (Member)

Counsel

Helga D. Van Iderstine, K.C. and Tan Ciyiltepe for the Complaints Investigation Committee (the “CIC”)

Mark Wasyliw, for Matthew Chorney

Jeff Hirsch, K.C. for the Panel

INTERIM REASONS FOR DECISION

I. Introduction

1. Mr. Chorney has been licensed as a registered paramedic since 2007 and as a member of the College since December 1, 2020.
2. He did not renew his certificate of practice in 2024.
3. Mr. Chorney was charged with a number of offences under a Notice of Inquiry dated July 12, 2024 (the “Notice”).
4. In summary, the Notice alleges that Mr. Chorney refused to go on a primary call for a patient on March 23, 2023, which turned out to be a priority 1 call, and that he subsequently refused to be interviewed by the College’s investigator, thereby failing to cooperate with the College’s investigation.
5. The CIC says that, in doing so, Mr. Chorney failed to demonstrate appropriate judgment in the practice of paramedicine, is guilty of professional misconduct, and finally, that he demonstrated an inability or unwillingness to comply with the requirements and standards of the College and is ungovernable.
6. The Panel convened an in-person hearing on April 28 and 29, 2025 attended by all parties, their counsel, and several observers.

7. As explained below, the parties agreed that the Panel had jurisdiction to proceed with the hearing.
8. Mr. Chorney entered a plea of not guilty to all charges.
9. The parties agreed on a number of matters and filed a Statement of Agreed Facts (the “SAF”) and a Book of Documents as exhibits to the proceedings.
10. The prosecution called three witnesses. Mr. Chorney testified on his own behalf and all the evidence was completed on the first day of the hearing.
11. The parties made submissions on the second day of the hearing as to whether the CIC met its onus of establishing on a balance of probabilities that Mr. Chorney is guilty of the charges. The prosecution sought to make submissions on penalty but counsel for Mr. Chorney argued that this argument ought to be made only if (and after) a conviction on one or more of the charges occurred.
12. The Panel reserved its decision, advising the parties that it would deliberate and issue written reasons for its decision and call the parties back for submissions on penalty, if required.
13. These are those reasons.

II. Jurisdiction of the Panel

14. In 2018, the *Practice of Paramedicine Regulation*, Man Reg 71/2018, was enacted under the Act which designated paramedicine as a regulated health profession. The Regulation established the College under the Act, and set out a scope of practice for the profession.
15. The *Practice of Paramedicine Regulation* was enacted on June 1, 2018 to:
 - (a) designate the profession of paramedicine as a regulated health profession;
 - (b) establish the College; and
 - (c) set out the scope of practice of the profession.
16. The *College of Paramedics of Manitoba General Regulation* Man Reg 104/2020 (the “Regulation”) came into force on October 30, 2020, and the College came into existence on December 1, 2020.
17. The Regulation sets out the membership classes of the College and the registration requirements for each class. It also sets out requirements for issuing and renewing certificates of practice, standards of practice for the profession, continuing competency requirements, requirements for professional incorporation by members of the profession, and the terms and conditions on the performance of reserved acts authorized for the profession under the *Practice of Paramedicine Regulation*, as well as the requirements of the Regulation.

18. Mr. Chorney was licensed as a registered paramedic with the Province of Manitoba pursuant to *The Emergency Medical Response and Stretcher Transportation Act, SM 1985-86, c. 7*. He has been so registered starting in 2007 and continuing until December 1, 2020 when the *Practice of Paramedicine Regulation* came into force and the College became active. At that point, and pursuant to subsection 12(1), he became a member of the College and subject to its standards and processes as set out in the Act and Regulation.

19. Mr. Chorney admitted that the College has jurisdiction to conduct this Inquiry.

20. Counsel also noted that, on August 1, 2024, Mr. Chorney executed a “Waiver of Time Frames” acknowledging service of the Notice and waiving the time requirements set out in section 116 of the Act for the commencement of the hearing.

21. On the basis of these representations, the Panel was satisfied that it had jurisdiction to hear and adjudicate on the matters before it.

III. Plea

22. As noted above, Mr. Chorney pled not guilty to all the counts in the Notice.

IV. The Evidence

IV.1 Agreed Facts

23. The facts that were not disputed by Mr. Chorney and are admissible as evidence are contained in the SAF and set out below.

24. At the material time, Mr. Chorney was part of paramedic unit IL1102 (the “Unit”), which operated out of the West St. Paul EMS Station at the intersection of Grassmere Road and the Provincial Trunk Highway.

25. On March 23, 2023, the Unit was comprised of Mr. Chorney and Ms. Victoria Archambault, who had been partnered by that point for approximately one year. The Unit was the day unit on shift on March 23, 2023 and had been covering the West St. Paul area on that day.

26. By March 23, 2023, Mr. Chorney had been practicing paramedicine in Manitoba for approximately 16 years. He was also designated as a Primary Care Paramedic-Intermediate Care (“PCP-IC”) at the relevant time.

27. On March 23, 2023, at approximately 19:30, the Unit, comprised of Mr. Chorney and Ms. Archambault, returned to West St. Paul EMS station from a prior emergency call. The Unit was scheduled for a shift from 08:00 to 20:00 on March 23, 2023.

28. At 19:51, the Medical Transportation Coordination Centre (“Dispatch”) received a 9-1-1 call from Middlechurch Home in West St. Paul for an 85-year-old woman, who was believed to have a partial airway obstruction with a decreased level of consciousness (the “Patient”).

29. At 19:52:36, Dispatch hailed the Unit for a status check. Ms. Archambault replied that the Unit was back at the station and available on the pager. Dispatch informed the Unit that there was a primary call for them and asked for the Unit to confirm their availability. Ms. Archambault advised that the Unit was available to take the primary call, which was also a priority 1 call, and which meant that there was an imminent threat to the life of the patient in distress.
30. At 19:53:07, Dispatch advised the Unit of the Patient location, which was at 280 Balderstone Road (“280 Balderstone”), in Winnipeg, Manitoba. The Patient’s location was directly across the Provincial Trunk Highway from the West St. Paul EMS Station.
31. The time it would have taken the Unit to arrive at 280 Balderstone would have been approximately two to three minutes.
32. At 19:53:25, Mr. Chorney acknowledged the details of the call but unilaterally declined the call, informing Dispatch in front of Ms. Archambault that the Unit would not be starting another primary call at the end of his shift. This decision was made by Mr. Chorney without consultation with Ms. Archambault.
33. At 19:53:41, Dispatch acknowledged this update and reassigned the priority 1 call to another unit and marked the Unit off duty.
34. At 19:54:57, Dispatch assigned Selkirk EMS, Unit IL08SPR (the “Selkirk Unit”) to the call and the Selkirk Unit was marked enroute by 19:58:46.
35. At 20:12:22, the Selkirk Unit was marked on scene by Dispatch. Upon arrival the Selkirk Unit noted that the Patient was in respiratory distress with an initial blood oxygen level of 79%. She appeared to have aspirated on either vomit or saliva. The Patient’s condition improved during their treatments and she was taken to a nearby hospital.
36. It took the Selkirk Unit approximately 19 minutes to arrive on scene for the priority 1 call.
37. On March 23, 2023, Mr. Chorney did not advise Ms. Archambault as to why he declined to attend the primary call.
38. An internal investigation was commenced by Mr. Wayne Bustard, Manager of EMS Health Services, on behalf of Shared Health. While the Shared Health investigation was ongoing, Mr. Chorney was placed on paid leave as a result of his refusal of the call on March 23, 2023.
39. On April 17, 2023, Mr. Chorney was interviewed by Mr. Bustard and Ms. Jocalyn Houghton, HR Consultant for Labour relations. Ms. Rebecca Clifton, Union Representative for Mr. Chorney, was also present for the Shared Health interview. The purpose of the Shared Health interview was to gather information with respect to the March 23, 2023 refusal to attend a call and to give Mr. Chorney an opportunity to provide any specific information to assist with the Shared Health investigation.
40. During the interview, Mr. Chorney acknowledged that:
 - (a) the Dispatch record was an accurate reflection of what occurred on March 23, 2023;

- (b) he advised Dispatch that he was not going to start another primary call at the end of his shift;
- (c) paramedics must act in good faith and provide care in accordance with the patient's best interests pursuant to Shared Health Policy A01; and
- (d) the Unit was two minutes away from the Patient in distress;

41. During the Shared Health investigation, Mr. Chorney stated that he called the EMS on-call supervisor ("OCS") on duty at the time of the March 23, 2023 refusal to attend a call and claimed that he called the OCS to initiate the provincial fatigue policy (the "PFP").

42. Shared Health investigated and found no evidence that he had made a call to the OCS before refusing to attend the call.

43. The Shared Health investigation found that Mr. Chorney:

- (a) failed to attend the primary call;
- (b) failed to comply with Shared Health policy or procedure with respect to fatigue, or refusing a call;
- (c) if fatigued as he claimed, he was still obligated to contact the OCS to determine the best course of action so that patient safety and care was not compromised;
- (d) failed to recognize that his refusal to go on the call involved a patient's threat to life; and
- (e) misled the investigation into his conduct on March 23, 2023 by maintaining that he contacted the OCS on duty, even though Shared Health call logs showed no incoming call from his phone number, and Mr. Bustard, the OCS on March 23, 2023, was never contacted by Mr. Chorney before, or after, he refused to go on the primary call.

44. Mr. Chorney was terminated from his position with Shared Health's Emergency Response Services on May 25, 2023, due to his refusal to attend the primary call on March 23, 2023.

45. On or about June 1, 2023, the College informed Mr. Chorney that an employer's report was received from Mr. Bustard on April 14, 2023, regarding the March 23, 2023 primary call. As a result of the employer's report, the Registrar of the College referred the matter to the CIC.

46. On July 27, 2023, Mr. Chorney sent an email to the College regarding the referral to the CIC. He advised the College that he initiated the PFP on March 23, 2023. He stated that he called the OCS at the end of the shift to put the Unit out of service due to fatigue and stated that the OCS refused to answer their phone. He stated that he had a medical note regarding his medical illness placed on his file at Shared Health some years ago as a result of several legal disputes with his former employer.

47. On August 8, 2023, Mr. Chorney provided the College with further information regarding the PFP he allegedly invoked on March 23, 2023.

48. On September 14, 2023, the College sent a letter to Mr. Chorney requesting additional information in written form (the "September letter"). The College sought additional information

about, among other things, his current plan to practice as a paramedic, his ability to practice safely, his plan as to how he will manage fatigue related to his employment, and his current medical restrictions he has related to shift work.

49. Mr. Chorney did not provide a written response to the September letter before the College's deadline of October 13, 2023.

50. On October 4, 2023, Mr. Chorney had a discussion with the College regarding the College's request for additional information.

51. On or about October 13 and 19, 2023, the College attempted to communicate with Mr. Chorney to remind him of the deadline to respond to the College's request for additional information.

52. On November 14, 2023, the College sent a letter to Mr. Chorney by way of email to remind him that he had yet to respond to the College's request for additional information.

53. On November 24, 2023, Mr. Chorney called the College and spoke with the Executive Director/Registrar of the College, Ms. Corene Debreuil (the "Registrar") about the complaint.

54. On January 23, 2024, the Registrar called Mr. Chorney to inform him that the CIC appointed an external investigator to investigate the March 23, 2023 call and the employer's report.

55. On March 8 and 12, 2024, the investigator, Mr. Robert Marshall (the "Investigator"), was provided with Mr. Chorney's email address and he sent an email to Mr. Chorney to arrange for a time to discuss the March 23, 2023 call. Mr. Chorney did not respond to this email and request to participate in the investigation of the College.

56. On March 14, 2024, the Investigator emailed Mr. Chorney again to arrange for a time to speak. Mr. Chorney did not respond to this request as well.

57. Mr. Chorney did not reply to multiple requests by phone and email to arrange for an interview with the Investigator.

58. During the course of the College investigation, Mr. Chorney never responded to the Investigator's requests for an interview.

59. On April 4, 2024, Mr. Chorney called the College and spoke with Sharon Connors. He did not provide a response to the Investigator.

60. To date, Mr. Chorney has not spoken to the Investigator or responded to him.

IV.2 Witness Testimony

61. The prosecution called three witnesses: Ms. Debreuil, Mr. Bustard, and Ms. Archambault.

62. Mr. Chorney testified on his own behalf.

Ms. Debreuil

63. Ms. Debreuil is the current Registrar of the College and has been in that position since December 1, 2023. From approximately mid-October 2023, she had been overlapping the position's responsibilities with the outgoing Registrar, Trish Bergal. By mid to late November 2023, Ms. Debreuil was working independently in her role with occasional assistance from Ms. Bergal.

64. She explained her general duties as Registrar as including overall responsibility for the conduct process and compliance with the Act and maintaining the register of certified paramedics and Emergency Medical responders.

65. In those areas of responsibility, Ms. Debreuil was assisted by two College employees. Caralee Barrault, at the relevant time, was the Program Assistant for conduct/registration. Sharon Connors was and continues to be the Registrar's Executive Assistant, monitoring the public face of the College on communications and managing the College calendar. Ms. Connors would cover for Ms. Barrault in her absence.

66. Ms. Debreuil testified that the September letter was seeking additional written information as the College's concern was there was an indication of a medical condition and Ms. Bergal wished to ensure the CIC had all the information about it.

67. The College requires information at first-time registration and at renewal about, among other things, whether the applicant/member has a mental or physical condition that might impair their ability to practice safely. Mr. Chorney had never made any such self-declaration in the past.

68. With respect to the September letter, Mr. Chorney was sent a reminder email on October 19, 2023.

69. The College sent him an additional reminder letter on November 14, 2023.

70. No reply was received to either correspondence.

71. On November 22, 2023, Ms. Debreuil was advised by email from Ms. Connors that she had received a phone call from the courier sent to deliver documents to Mr. Chorney. The courier was in his vehicle, reported that Mr. Chorney had refused to receive the package from the College, and the courier was uncertain how to proceed.

72. On November 24, 2023, Ms. Debreuil called Mr. Chorney as she was of the view that she could perhaps make a connection with him and get answers to the September letter.

73. During that call, Mr. Chorney did not disclose that he had any medical or sleep problems.

74. The College wrote again to Mr. Chorney on January 24, 2024, informing him that an investigation had been authorized.

75. On April 4, 2024, Mr. Chorney called Ms. Connors and told her, among other things, that: he had told Ms. Debreuil about his conditions; the courier was aggressive and Mr. Chorney was upset by that; he would not respond to the September letter; and he did not want to be contacted by the College anymore.

76. On April 16, 2024, the College sent Mr. Chorney the investigation report dated March 20, 2024 and never received any response from Mr. Chorney.

77. Ms. Debreuil testified that she understood Mr. Chorney's explanations for refusing to attend the call on March 23, 2023 as him wanting to make it clear he would not work overtime. She says that he never raised the issue of fatigue as an explanation and has never provided information to the College to support that claim.

78. Ms. Debreuil estimated the College's costs inclusive of the investigation to be approximately \$32,000.

79. On cross-examination, Ms. Debreuil acknowledged that when she first took on her position with the College she was "learning as she went" and that this matter was her first complaint that was referred for an investigation.

80. While accepting that it was possible Mr. Chorney had other conversations with College staff which were not documented or recorded, Ms. Debreuil noted that staff are aware there is a protocol to document any such discussions.

81. She reiterated that it was absolutely clear that Mr. Chorney wanted to retire but in order for him to revert to retired status, he had to answer the questions in the September letter. She disagreed with the suggestion that Mr. Chorney did everything he could to convert to retired status.

82. Ms. Debreuil confirmed that she told Mr. Chorney he had to be interviewed and that it would be consequential to him if he was not interviewed and he could be charged with misconduct.

83. She acknowledged that her notes of the November 24, 2023 call with Mr. Chorney were not verbatim and were cleaned up by her after the call for spelling and grammatical errors.

84. She said the call was expansive and wide-ranging on many topics, but the essence of the conversation was Mr. Chorney saying this was a systemic problem based on Shared Health relying too heavily on overtime to make up for understaffing. Mr. Chorney maintained that fatigue and burnout were a problem in the profession and put Manitobans at risk. Ms. Debreuil said he spoke in these broad terms but not to the March 23, 2023 refusal.

Mr. Bustard

85. Mr. Bustard is employed by Shared Health as a Manager of EMS Health Services and was the West St. Paul EMS Station District 2 Manager and OCS on duty on March 23, 2023. He was responsible for operational decisions for the zone that day.

86. He testified that, at the time, the West St. Paul EMS Station had two ambulance units: a 24-hour ambulance and 12-hour day ambulance. On March 23, 2023, when the call in question came in, only the day ambulance was available from 08:00 to 20:00 as the 24-hour truck was not in service and unable to respond.

87. Mr. Bustard stated that he received a call from Ms. Archambault who told him that her partner, Mr. Chorney, refused to respond to a call, and put their unit out of service. He said Ms. Archambault was audibly upset, crying, and worried about the impact of Mr. Chorney's actions on her career. Ms. Archambault told him that Mr. Chorney had left the station, and she did not know if he had called anyone.

88. Referring to the Medical Transportation Coordination Centre Issue Tracking Report for March 23, 2023 (the "MTCC Report") at Tab 4 of the Book of Documents, Mr. Bustard noted that it had an entry at 19:53:25 which showed "IL1102 acknowledges the details, stating "you're gonna have to put IL1102 out for end of shift at this point, we're not going to be starting another primary there". Mr. Bustard said this would have been Mr. Chorney's words on the radio.

89. On the issue of whether Mr. Chorney spoke to him as OCS on the telephone, Mr. Bustard testified that he did not speak with Mr. Chorney. Further, Mr. Bustard checked the incoming calls on his phone (the OCS line), other managers checked their phones, and no one found any calls or voicemail messages from Mr. Chorney. He stated there were no routing issues for his phone.

90. The call log for Mr. Bustard's phone (Tab 35) showed Ms. Archambeault's call at 20:01 and this was his only incoming call from the West St. Paul station.

91. Mr. Bustard's evidence was that Mr. Chorney never called the OCS line on March 23, 2023.

92. Mr. Bustard confirmed that he was familiar with the PFP (the *EMS Fatigue – Self Identified Removal from Service Process* at Tab 9). He said that if a paramedic deems themselves to be tired, they would be obliged to call the OCS line, speak to the OCS, and if it was determined the paramedic could not take the service request, the OCS would do whatever was needed to ensure the paramedic's safety, and then explore options for a response if there was an emergent call. He said this was a process that had occurred in the past.

93. Mr. Bustard stated that paramedics are expected to work overtime and that, if they could not do so, they would be expected to call the OCS line.

94. Under the PFP, the paramedic is required to complete the Post Fatigue Declaration form and submit the completed form before the end of their next scheduled shift.

95. Mr. Bustard stated that neither he nor his colleagues ever received a completed Post Fatigue Declaration form from Mr. Chorney.

96. Under cross-examination, Mr. Bustard acknowledged that nobody could tell someone else if they are fatigued or not and that this is effectively a self-evaluation.

97. He acknowledged that he did not ask for his colleagues' call logs for that day and took them at their word when they told him they had no record of any calls from Mr. Chorney.

98. Mr. Bustard agreed that, prior to this incident, he considered Mr. Chorney to be a skilled, talented paramedic without any previous complaints against him. He reiterated however that he thought Mr. Chorney's actions that day constituted professional misconduct and that is why the employer commenced an investigation.

Ms. Archambault

99. Ms. Archambault has been a paramedic since 2008, previously working out of Parkland, Interlake, Stonewall, Oakbank, Selkirk, and for the past three years, the West St. Paul EMS Station.

100. Her partner on March 23, 2023 was Mr. Chorney and they had been working the day shift – 08:00 to 20:00.

101. She testified that she and Mr. Chorney were at the station at 19:52 when the dispatch call came in requesting their unit's location. She was sitting at the station's computer and replied they were back in station. At 19:53:07, the 911 call at the Middlechurch Home, 280 Balderstone Road, was assigned to their unit. At 19:53:25, Mr. Chorney took their unit out of service and declined the assignment.

102. Ms. Archambault stated that Mr. Chorney never told her he was too fatigued to take the assignment. She said she did not see Mr. Chorney making any phone calls after that.

103. After Mr. Chorney refused the assignment, she proceeded to put away narcotics and that would have taken about two minutes.

104. Ms. Archambault said she saw Mr. Chorney leave the station just before her and she said he had a car at the station which he would have driven.

105. At 20:01, she called Mr. Bustard who was the OCS at the time. She said she had no difficulty getting through to Mr. Bustard.

106. She testified that she finished her shift at approximately 20:20.

107. Under cross-examination, she stated she was not aware of Mr. Chorney having chronic sleep or fatigue issues.

108. She acknowledged being aware that Mr. Chorney did not like overtime but that she believed their unit was obligated to respond to the call that came in near the end of their shift.

109. Ms. Archambault could not recall if she and Mr. Chorney did a vault count that evening but was certain that Mr. Chorney could not have started one without her seeing or knowing about it.

110. She admitted that it was an assumption on her part that Mr. Chorney drove away from the station in his own car.

111. She testified that she had never experienced any difficulty reaching an OCS by phone or having her calls forwarded and had not heard of any issues about this.

Mr. Chorney

112. Mr. Chorney testified that he is 38 years old and has been practising for 16 years as a paramedic while also working as a paramedic educator for various institutions including at Red

River Community College, Assiniboine College, and in the Interlake Eastern region. He stated it was his intention to be retired.

113. He stated that he has a variety of medical issues including having sleep difficulties over the past 12 years. Over that period, he has had to adjust when he works his shifts (to avoid night shifts) and that he applied for the position at the West St. Paul station in order that he could work straight days.

114. In December 2014, he obtained a note from a Nurse Practitioner at the Riverton Community Health Centre (Tab 38) which noted that altering his shifts to include nights “would not be helpful with his ongoing sleep disturbances...”.

115. Mr. Chorney stated that he was working 12-hour days, four days on and four days off, at West St. Paul, and that he found it hard to catch up on his sleep and often only slept for four hours a night.

116. On the issue of overtime, he said he was often asked to work overtime but he did not take optional overtime work. He noted that he and Ms. Archambault had different views on overtime and clashed on the subject.

117. With respect to the events of March 23, 2023, he said he was feeling very tired when the assignment came in, and he recognized the assignment was for a personal care home. He stated he was just too fatigued and there was no way he could do it. He said he asked Ms. Archambault not to place the unit on the call. He described there being a “back and forth” with Ms. Archambault about this. He said he told her he was too tired to go on the call and, after Ms. Archambault put them on the call, he took the unit off the assignment as they were at the end of their shift. He noted that Ms. Archambault disagreed with his decision.

118. Mr. Chorney testified that he then attended on his own to securing their unit’s narcotics and started the process of doing a vault count. He estimated this took him about nine minutes doing it on his own.

119. He referred to the PFP and stated that it permitted paramedics to take themselves out of service once they let their employer know. He testified that the reason for the PFP is to avoid medication errors, car accidents, and other errors or mishaps.

120. Mr. Chorney testified that he had previously raised with management the fact that he had experienced brain fog, that it was taking him longer to make decisions, and that he felt unsafe to drive.

121. On March 23, 2023, he said he had finished his paperwork, and after he took the unit of service, he packed to leave the station and called the OCS from the car.

122. Mr. Chorney stated that his girlfriend likely picked him up and drove him home.

123. He testified that when he called the OCS, the call went to a general phone number and it was forwarded. He said that he had issues over the years getting hold of the OCS and had previously called the OCS and not heard back. When he called that day, he said he left a voicemail message.

124. Mr. Chorney's evidence was that he filled out the Post Fatigue Declaration form on the station's computer and sent it on March 24, 2023.

125. Mr. Chorney also testified as to his knowledge of the Middlechurch Personal Care Home which was located at 280 Balderstone. He said he had spent lots of time there and was very familiar with it. He stated that the staff there had suction and oxygen and first aid skills.

126. As to the September letter, Mr. Chorney stated that he responded to that request for information from the College via, at minimum, three separate phone calls with one or more of Ms. Bergal, Ms. Debreuil, Ms. Connors, or Ms. Barrault.

127. On the issue of his desire to retire from practice, he referred to a series of text messages with Ms. Debreuil (Tab 25) which he said confirmed that he wished to change over to retired status. He denied telling the College that he intended to continue in practice.

128. Mr. Chorney provided a detailed description of his interaction with the courier sent by the College on November 22, 2023. He said the courier had not identified himself and left an envelope between the front doors of his house. He refused to sign for the letter so the courier took the letter back and went and sat in his vehicle. Mr. Chorney approached the vehicle, knocked on the window, and told him to leave Mr. Chorney's yard. The courier told him he needed instructions, and Mr. Chorney said the courier then got confrontational and aggressive with him. Mr. Chorney told him he would call the RCMP as the courier was being threatening and the courier then drove away at speed.

129. Mr. Chorney said he was informed by the College only that there may be an investigation but that he was repeatedly told by the College that it was "okay if he was going to retire".

130. Mr. Chorney denied receiving the emails dated March 8, 12, and 14, 2024 from the Investigator and said he had no reason to check his email messages as he spent a lot of time working outside. He denied ever receiving any calls or voicemail messages from the Investigator.

131. He stated that, as far as he was concerned, the "College business was done".

132. When he was informed of the results of the College investigation, he was very frustrated and phoned the College on April 4, 2024. He said he told Ms. Connors that he thought the investigation was closed and wanted to know why he was not in "retired" status. He stated Ms. Connors told him the investigation was now done.

133. As to his call with Ms. Debreuil on November 24, 2023, he disagreed with Ms. Debreuil's summary of the call. He said he told her that he was currently no longer fatigued and was feeling and sleeping better.

134. Overall, Mr. Chorney denied using fatigue as an excuse for not going on the call on March 23, 2023. He stated that he continues to believe that fatigue is a serious issue for the profession and the public was being put at risk. He said he many amicable phone conversations with the College and he "gave them everything they asked".

135. Under cross-examination, Mr. Chorney asserted that Ms. Archambault had started the narcotics count at the time the call had come in and that she was mistaken when she said otherwise in her direct examination.

136. When it was suggested to him that he never told the College about the narcotics count issues at the time, Mr. Chorney claimed that he had told both Ms. Bergal and Ms. Debreuil. He said he raised this issue with his employer.

137. With reference to the circumstances at 280 Balderstone, Mr. Chorney acknowledged he had no special knowledge of what the nurses at the facility did but maintained they would have first aid training.

138. He admitted that he never produced his cell phone records to demonstrate he had called the OCS but said he had no reason to produce them. He was aware Mr. Bustard said there was no record on the log of Mr. Chorney's call but reiterated that many calls were missed by the OCS.

139. When asked about receipt of the College's January 25, 2024 letter which advised of the Investigator's appointment (Tab 22), he admitted that he had understood he might be contacted by an investigator and that the letter showed his email address but he was "hard pressed to say if he saw it [the letter] or not".

140. Mr. Chorney maintained he was calm when the courier came to his house and said he referred to the courier as a "psychopath" because he would not identify himself to Mr. Chorney.

141. Mr. Chorney could not say if or when he saw the College's June 1, 2023 letter (Tab 6) advising of the Registrar's referral to the CIC. He acknowledged that his only written response to this letter was his email dated July 27, 2023 (Tab 7).

142. He admitted that he had never informed the College of his fatigue issues before then.

143. Mr. Chorney stated that he could not say if he received the College's letter dated April 16, 2024 (Tab 29) attaching the Investigator's Report.

144. He stated that he told the College he "enacted the [PFP on March 23, 2023 and] nothing else beyond that happened." (Tab7)

145. Mr. Chorney asserted that he could not safely treat that patient that day.

V. Position of the Parties

146. The parties agreed that the onus on the prosecution was the civil standard of a balance of probabilities - that is, whether the relevant evidence shows it is more likely than not that an alleged event occurred (see *F. H. v. McDougall*, 2008 SCC 53, at para. 49).

V.1 The CIC

147. The CIC submitted that the evidence clearly demonstrated that Mr. Chorney refused to go on a primary call for a patient on March 23, 2023, and that he subsequently refused to be interviewed by the College's investigator, thereby failing to cooperate with the College's investigation. The prosecution argued that these actions constituted professional misconduct.

148. Ms. Van Iderstine stated that Mr. Chorney's refusal to go on the call and his failure to cooperate with the College's investigation calls into question his judgment, ethics, and integrity.

149. Counsel for the CIC stressed that the case was not about Mr. Chorney's skills as a paramedic or paramedic educator, the reasonableness of the PFP, the policy relating to narcotic counts at the end of a shift, or the available resources at 280 Balderstone. Ms. Van Iderstine suggested that the case was about Mr. Chorney's failure to respond to a call and assist when called upon to do so and his obligation, as a registrant of the College, to participate in the College's investigation.

150. On the duty to cooperate in regulatory investigations, the Panel was referred to *The Law of Regulatory Investigations* (2023) by James T. Casey, K.C., at pp. 81-82:

One of the key functions of self-regulating professions and other regulatory regimes is to ensure that the individuals governed by the regime abide by rules and requirements set by the legislation or the regulator as these are aimed at protecting members of the public. When a complaint of misconduct is made or wrongdoing is discovered, regulators have a responsibility to investigate and, if necessary, implement sanctions to protect the public. The ability to sanction can only effectively occur where the regulatory body has the ability to fully investigate when confronted with a complaint or concern. A full and complete investigation allows a regulatory body to deal effectively with the concerns being investigated and provides confidence to the general public that it can rely on the regulatory body.

Interviewing individuals, including the investigated person, and obtaining documents and other evidence relevant to the investigation are critical aspects of the investigation.

...individuals who choose to not cooperate or respond promptly and substantively interfere with the proper functioning of the regulator, diminish the public's respect for the regulatory body and the regulatory process, and cause otherwise avoidable expense to be incurred.

151. Ms. Van Iderstine invited the Panel to find Mr. Chorney guilty of professional misconduct contrary to s.124(2) (a) of the Act; having contravened the *Code of Ethics* (the "Code"), the *Standards of Practice* (the "Standards"), and a practice direction, all contrary to s.124(2)(b) of the Act; having displayed a lack of judgment in the practice of paramedicine contrary to s.124(2)(d) of the Act; conduct unbecoming a member contrary to s.124(2)(h) of the Act; and/or having demonstrated an inability or unwillingness to comply with the requirements and standards of the College to such a degree as to show himself to be ungovernable.

152. With respect to “professional misconduct”, counsel cited the test formulated in *Strother v. Law Society of British Columbia*, 2018 BCCA 481 (at para. 64):

[A] hearing panel will consider whether the ... conduct was a marked departure from the conduct expected of [a professional]. Put another way, the ... conduct must display culpability of a gross or aggravated nature, rather than a mere failure to exercise ordinary care.

153. Referring to *Kuny v. The College of Registered Nurses of Manitoba* 2017 MBCA 111 at para. 72, counsel emphasized:

The proper test for whether the conduct of a professional crosses the line and becomes misconduct is whether the individual, in the pursuit of his or her profession, has done something which would reasonably be regarded as improper by his or her professional peers of good repute and competency.

154. Where there were any inconsistencies in the evidence, CIC counsel asked the Panel to make findings of credibility against Mr. Chorney. Ms. Van Iderstine requested that the Panel consider all the evidence, including the witnesses’ testimony, the documents, and the SAF. The prosecution referred the Panel to the *McDougall* case (cited above) at para. 58, where the Court noted that a trial judge “should not consider the [witness’] evidence in isolation but must look at the totality of the evidence to assess the impact of the inconsistencies in the evidence on questions of credibility and reliability pertaining to the core issue in the case.”

155. Ms. Van Iderstine noted that most of Mr. Chorney’s evidence at the hearing was heard by the CIC for the first time and was not credible. Among other things, she emphasized the following:

- (a) It was untrue that he spoke to Ms. Archambeault about whether to go on the call prior to declining the call;
- (b) He had no way of knowing the call was not an emergent or serious call when he declined the call;
- (c) He made no call to his OCS before 19:50 to say he was too tired to go on the call;
- (d) There is no evidence he reported fatigue that night;
- (e) There is no evidence the PFP form was ever received by anyone;
- (f) He should not be believed when he testified he did not know the investigator’s name when it was disclosed to him in the letter of January 25, 2024;
- (g) He never reported to the College on his registration renewals that he was suffering from a physical/mental condition such as fatigue;
- (h) Ms. Debreuil testified that Mr. Chorney told her on January 24, 2024 that he did not have a medical condition;
- (i) His nurse practitioner’s note was not a medical report, was 10 years old, and addressed night shifts not his ability to work overtime;
- (j) His reaction to the courier attending at his house was completely unreasonable and demonstrates his resistance to cooperating with the College;
- (k) Mr. Bustard testified he never received a call claiming fatigue from Mr. Chorney;
- (l) Ms. Archambeault was unaware of any fatigue issues for Mr. Chorney that evening, denies that he told her he was too tired to go on the call, and she did not witness him

calling the OCS nor did she see any evidence Mr. Chorney did a narcotic count that evening; and

- (m) Mr. Chorney was unable to identify the name of the person he says picked him up from work that night.

156. Counsel for the CIC submitted that Mr. Chorney breached his legal obligations to attend on the call and cooperate with the investigation, citing subsections 82(1) and 82(2) of the Act. These sections of the Act allow the College to establish the standards of practice that the prosecution says Mr. Chorney failed to meet. Additionally, Ms. Van Iderstine referenced section 99 of the Act that imposes an obligation on a regulated member to answer questions or provide information to an investigator when required to do so.

157. Ms. Van Iderstine argued that Mr. Chorney breached the overall goal of the Code by failing to prioritize the health of the public. By failing to attend, Mr. Chorney put the patient at risk and the prosecution was not obliged to show actual harm to the patient, only that there was delay which increased the risk of harm to the patient.

158. The CIC's position is that it would have been the most efficient and effective response to the call if Mr. Chorney's unit had responded and that Mr. Chorney simply declined the call without exploring any other options such as having another unit do a subsequent transport of the patient.

159. The prosecution asserted that Mr. Chorney did not comply with the *Standards of Practice for the Paramedic Profession* in that he did not satisfactorily complete his obligations and did not explain why he did not meet these expectations. They submitted that he was not accountable for his failure to act.

160. Further, they argued that Mr. Chorney had not complied with the *Practice Directions and Expectations on Registrant and Employer Responsibilities* (the "Practice Direction") – specifically, under the Duty to Report - Self-Disclosure Requirements to disclose a physical or mental condition which might impair his ability to practice in a safe and effective manner (p.12), and the Duty to Comply with an Investigation requirement (p.14).

161. With respect to the scope of the duty to cooperate, counsel referred to the Casey text at pp.86-87:

Investigated persons are required to cooperate fully with investigators...[The duty] does require that an investigated person:

Acknowledge and respond to correspondence in a timely and responsive manner;

...

Attend and participate in an interview and answer questions;

Not obstruct an investigator in carrying out their duties. Obstruction... can include...merely a failure to do something.

...

Examples of behavior and action that has been found to be a failure to cooperate also include:

Abusive, threatening, belittling, or intentionally obstructive behavior during an investigation;

162. Relying on the *Law Society of Ontario v. Diamond* 2021 ONCA 255 at para. 50, the CIC submitted that Mr. Chorney demonstrated a failure to cooperate as he did not act responsibly and in good faith to respond promptly and completely to the College's inquiries and to the investigation and that this constituted professional misconduct.

163. The CIC asserted that a registrant has a fundamental responsibility as a regulated professional to participate in an investigation and this is what they voluntarily submit to by being registered.

164. Finally, the prosecution urged the Panel to treat as irrelevant Mr. Chorney's evidence that he wished to retire and that the College was prepared to allow him to do so without the investigation being completed. Counsel stressed that the evidence of the College was directly to the contrary. In addition, counsel made the point that a paramedic could not simply walk away from practice in Manitoba without being held accountable as they could go to another jurisdiction and practice as a paramedic without the regulator there or the public being informed.

V.2 Mr. Chorney

165. Mr. Wasyliw submitted that Mr. Chorney was an exceptional paramedic and paramedic educator. He noted that Mr. Chorney had significant sleep issues and simply could not work more than 12 hours at a time.

166. He stressed that fatigue in the paramedic profession is a real issue and constituted a threat to patient safety in a variety of different ways – making errors in diagnosis, administering the wrong medications, potential for accidents while driving on rural roads, etc. He submitted that this was the rationale to permit self-reporting for fatigue, and this allowed for paramedics to refuse “dangerous work”.

167. Mr. Wasyliw referred to Mr. Bustard's testimony and stated that the point of having an OCS available by phone is for management to be informed and problem-solve. He suggested that Mr. Bustard conducted himself inappropriately by commencing an investigation without contacting Mr. Chorney.

168. With respect to Ms. Archambault, counsel described her as an “unreliable historian” who was distraught and crying at the time she called the OCS.

169. Mr. Wasyliw asserted that Mr. Chorney was not aware the call was a priority call at the time he refused to attend on the call.

170. The defence submitted that Mr. Chorney was occupied when the call came in following the legally required narcotic protocol which meant that there was no time to complete both of his duties. In Mr. Wasyliw's words, Mr. Chorney could not “just run out of the station”.

171. Mr. Wasyliw suggested that there was no adverse impact on the patient by having the other unit attend on the call. He stated that that the personal care home would have had a physician on duty and would have had crash carts available.

172. He noted that Mr. Chorney testified he was picked up from work by someone else as he did not feel safe to drive home and that this was evidence of Mr. Chorney's fatigue that evening.

173. Mr. Wasyliw asserted that Mr. Chorney had in fact called the OCS line and that there was evidence (from Mr. Chorney) of calls to the OCS line that had historically been missed. He asserted that Mr. Bustard ought not to be believed when he testified there was no record of missed or improperly routed calls.

174. As to Mr. Bustard's evidence that the other five or six individuals who might have received a call that evening from Mr. Chorney had not received a call, Mr. Wasyliw suggested there was no evidence about the searches/inquiries made by those people. Further, he noted that Mr. Bustard never checked the station computer from which Mr. Chorney said he sent the PFP form. He described this as a "half-measure".

175. Mr. Wasyliw referred to the screenshot from the mobile phone (Tab 39) as suggesting Mr. Chorney did in fact call the OCS line that evening. He dismissed the CIC's argument that Mr. Chorney had not produced his cell phone records by pointing to Mr. Chorney's testimony that he had never been asked to do so by the College.

176. From Mr. Wasyliw's perspective, there is no credible evidence that Mr. Chorney did not follow protocol that evening or thereafter and no evidence that he lied to or deceived his employer about what occurred.

177. Mr. Wasyliw described Mr. Chorney's response to the College investigation and the College's conduct of the investigation as "fumbling through it". He described Mr. Chorney's pattern as making a phone call when he received a letter and that there were conversations that occurred with the College which are not reflected in the documents. He stated Mr. Chorney clearly expressed his intention to retire.

178. Mr. Wasyliw argued that it was unreasonable and not in good faith for the College to say Mr. Chorney never responded to the September letter.

179. With respect to the incident involving the courier, Mr. Wasyliw pointed to the evidence that the courier was not uniformed, not identifiable, and did not identify himself as a representative of the College. He stated the courier made Mr. Chorney uncomfortable which caused him to become defensive.

180. Mr. Wasyliw asserted that the Investigator was not fair and independent as he was paid and directed by the College.

181. He argued that Mr. Chorney was not checking his emails between March 8 and 14, 2024 as he was "outside" and Mr. Wasyliw asked "why would he [check]?". He took issue with the Investigator only allowing 12 days for a response and suggested this was not in good faith.

182. Mr. Wasyliw suggested that Mr. Chorney had offered to come to the College and explain but no one took him up on it. He stated that the College was neither fair nor reasonable in their dealings with Mr. Chorney.

183. Mr. Wasyliw characterized as a “red herring” the fact that Mr. Chorney never advised the College of his sleep/fatigue issues because he could always get through his shift.

184. He asserted that Ms. Debreuil was inexperienced, that she admitted that her notes of the phone conversation with Mr. Chorney were not contemporaneous or verbatim and that she altered the notes after the conversation. Mr. Wasyliw asked the Panel to prefer the evidence of Mr. Chorney over the evidence of Ms. Debreuil.

185. Mr. Wasyliw characterized the conversation with Ms Debreuil as Mr. Chorney advocating for patient safety when he discussed the longstanding issue of paramedic fatigue and that the College should investigate that issue. He stated that this has been conflated with the suggestion Mr. Chorney was making a political statement when he declined to attend on the call on March 23, 2023.

186. As to the suggestion that Mr. Chorney never provided his cell phone records or medical records, he asserted that Mr. Chorney was never asked to produce them and that this was an attempt by the College to reverse the onus.

187. Mr. Wasyliw concluded by asserting that Mr. Chorney declined the call due to fatigue and his concern for patient safety, that he cooperated with the College, and that, overall, the prosecution failed to prove the allegations.

V.3 Reply by the CIC

188. Ms. Van Iderstine noted that the screen shot evidence of Mr. Chorney’s call to the OCS was unclear and essentially illegible and therefore did not constitute clear evidence that he had in fact called the OCS.

189. Ms. Van Iderstine stated that the College did not direct the Investigator as to how to do his investigation or what to put in his report and that the allegation the Investigator was not independent was unsupported and, in any event, irrelevant.

190. The CIC submitted that if Mr. Chorney intended to rely on his fatigue as a reason for declining the call, he had an obligation to adduce evidence of his fatigue and that he had failed to adduce any such credible evidence.

VII. Analysis and Findings

191. The authority of a Panel to make findings is found in subsection 124(2) of the Act.

192. The Panel has concluded that Mr. Chorney is guilty of professional misconduct and having contravened the Code, the Duty to Comply with an Investigation requirements of the Practice Direction, and the Standards. The Panel also finds that he is guilty of demonstrating a lack of

professional judgment. The Panel is not prepared to make a finding that Mr. Chorney is guilty of conduct unbecoming a member nor that he is ungovernable.

193. The reasons of the Panel supporting those conclusions follows.

VII.1 The refusal to go on the primary call on March 23, 2023

194. As noted above, the evidence is uncontroverted that, at 19:53:25 on March 23, 2023, Mr. Chorney unilaterally declined a primary call, informing Dispatch that the Unit would not be starting another primary call at the end of his shift.

195. Mr. Chorney's defence is twofold – he says he was too fatigued to go on the call, and it was therefore unsafe for him to do so and he says he was obliged to complete a mandatory narcotics count at the end of his shift and therefore could not leave the station to go on the call.

196. On the first defence, Mr. Chorney claims that his partner would have been aware of his fatigued state as they had been working almost a full shift prior to the call having come in. Ms. Archambeault denied having any knowledge of Mr. Chorney being too fatigued to go on a call. The Panel accepts her evidence on this point as she testified that she was surprised and upset when Mr. Chorney unilaterally declined the call. In addition, Mr. Chorney agreed, as part of the SAF, that he did not advise Ms. Archambault as to why he declined to attend the primary call – a direct contradiction of his testimony on the stand.

197. Mr. Chorney also says he called the OCS that evening to self-report his fatigue and that he thereafter filled out and filed the form required under the PFP. Both these claims are disputed by the CIC.

198. The Panel does not accept that Mr. Chorney called the OCS that evening.

199. Mr. Chorney's evidence of having done so, aside from stating he made the call, was a barely legible screenshot which purports to demonstrate the call having been made. The Panel is unable to draw that conclusion from the screenshot which does not contain sufficient detail to support the assertion.

200. The Panel noted that Mr. Chorney had not produced his cell phone records to show a call had been made and that it was up to him to do so, irrespective of whether the CIC asked him to or not. The Panel drew an adverse inference from his failure to produce his own cell phone records.

201. Mr. Chorney says there is a history of calls to the OCS being rerouted and/or lost. He provided no evidence in support of this, and the Panel considers this evidence to be self-serving and gave it no weight.

202. Moreover, the evidence of Mr. Bustard is clear that he received no call from Mr. Chorney and was not altered in cross-examination. Mr. Bustard did receive a call from Ms. Archambault which corroborates that the telephone line was operational that evening.

203. With respect to Mr. Chorney's evidence that he filled out and filed the PFP form, the evidence is clear that his employer never received any such form. The Panel heard no credible explanation as to how the form might have been misfiled or why there is absolutely no record of it

having been sent or received. In the circumstances, the Panel finds that Mr. Chorney did not submit this form to his employer.

204. As to the assertion by Mr. Chorney that he had started a mandatory narcotics count, Ms. Archambault disagreed and stated she did not see him doing this. The CIC argued that the narcotics vault count had never been raised by Mr. Chorney as an issue prior to the hearing. The Panel notes this as significant and telling. Taking all the circumstances into account, including Ms. Archambault's reaction to the call being declined, the Panel prefers Ms. Archambault's evidence and finds that Mr. Chorney was not doing a narcotics vault count when the call came in that evening and was not prevented from accepting the call for that reason.

205. In addition, the evidence was also uncontroverted that Mr. Chorney was not prepared to work any optional overtime and that, from his perspective, he did not agree with mandatory overtime. He was very clear that he thought fatigue within the paramedic profession was problematic and posed a threat to paramedic and patient safety.

206. In light of all of these factors, the Panel is persuaded that Mr. Chorney unilaterally and consciously chose to decline the primary call when it came in and that this constituted a breach of his obligations under the Code, and the Standards as referred to above. When he declined the call, he would have no way of knowing how emergent the Patient's situation was, and the Panel formed the opinion that this factor could not have been a factor in his decision-making.

207. The Panel is of the view that, in certain circumstances, there are compelling reasons for paramedics to have to accept calls near the end of their shift and work overtime. This call fell squarely into that category given the nature of the call and the proximity of 280 Balderstone to the West St. Paul EMS Station.

208. In considering whether Mr. Chorney's actions that evening constituted professional misconduct, the Panel was assisted by examining the behaviour of his peer, Ms. Archambault, that evening and assessing how she responded. Ms. Archambault was unhesitating in accepting the call and when Mr. Chorney subsequently took the Unit out of service, her distress was very evident. This certainly assists the Panel in finding that Mr. Chorney's response to the call would be a "marked departure from the conduct expected" of a paramedic. This is further buttressed by the subsequent discipline from Mr. Chorney's employer.

209. The Panel finds that Mr. Chorney's decision demonstrated a serious lack of professional judgment and constituted professional misconduct as well as a breach of the Code and the Standards.

VII.2 The failure to cooperate with the College's investigation

210. The evidence before the Panel demonstrates that Mr. Chorney did not reply to multiple requests by phone and email to arrange for an interview with the Investigator and, during the course of the College investigation, Mr. Chorney never responded to the Investigator's requests for an interview. He simply did not participate.

211. The obligation of Mr. Chorney to cooperate with the College's investigation is statutory and unambiguous.

212. Mr. Chorney's defence to this count appears to be based on his position that he was unaware of the communications seeking his involvement in the investigation and that, in any event, he had advised the College of his intention to retire from practice and the College represented to him that it was acceptable and no investigation was going to be required.

213. The Panel noted that Mr. Chorney's preferred method of communicating with the College consisted of phone calls and that he consistently refused to respond in writing (with one or two exceptions) when directed to do so. From the Panel's perspective, registrants must respond in writing to College inquiries to avoid precisely the type of ambiguities or misunderstandings that might arise from telephone conversations as occurred here.

214. With respect to the communications from the College pertaining to the investigation, the record shows that on January 23, 2024, the Registrar called Mr. Chorney to inform him that the CIC appointed an external investigator to investigate the March 23, 2023 call and the employer's report. Further, on March 8 and 12, 2024, the Investigator sent an email to Mr. Chorney to arrange for a time to discuss the March 23, 2023 call. Mr. Chorney did not respond to this email and request to participate in the investigation of the College. On March 14, 2024, the Investigator emailed Mr. Chorney again to arrange for a time to speak. Mr. Chorney did not respond to this request.

215. Mr. Chorney testified that based on the College's January 25, 2024 letter which advised of the Investigator's appointment (Tab 22), he admitted that he had understood he might be contacted by an investigator and that the letter showed his email address but he was "hard pressed to say if he saw it [the letter] or not".

216. As to the March 2024 emails from the Investigator, Mr. Chorney denied receiving them and said he had no reason to check his email messages as he spent a lot of time working outside. He denied ever receiving any calls or voicemail messages from the Investigator.

217. The Panel noted that Mr. Chorney stated that, as far as he was concerned, the "College business was done". Mr. Chorney said he was repeatedly told by the College that it was "okay if he was going to retire".

218. Where there is conflicting evidence on whether the College informed Mr. Chorney there would be no investigation, the Panel prefers the evidence of the College. It defies credulity that either Ms. Debreuil or Ms. Connors would say this to Mr. Chorney when all the College's actions in appointing the Investigator, conducting an investigation, and receiving an investigation report plainly show otherwise.

219. Overall, the Panel considered Mr. Chorney's testimony to be evasive and defensive. And where his evidence conflicted with the testimony of Ms. Archambeault and Ms. Debreuil, the Panel preferred their evidence.

220. The Panel formed the impression that because Mr. Chorney wanted the matter closed without an investigation, he effectively ignored all communications to the contrary. In essence, he did not cooperate with the College's investigation because he wanted to retire and did not want there to be an investigation.

221. It is not up to a registrant to decide the steps to be taken by a regulator in its conduct and discipline process. Mr. Chorney, by his approach to dealing with the College, was effectively attempting to do just that. This behaviour was unprofessional and unacceptable.

222. The Panel therefore finds that the prosecution has met its onus and proved that Mr. Chorney demonstrated a serious lack of professional judgment, breached the Code and the Standards, the Duty to Comply with an Investigation requirement of the Practice Direction, and committed professional misconduct.

223. The prosecution also sought a finding that Mr. Chorney had breached the Duty to Report - Self-Disclosure Requirements of the Practice Direction to disclose a physical or mental condition which might impair his ability to practice in a safe and effective manner. The Panel noted that this allegation was not particularized in the Notice. In addition, the Panel heard no persuasive evidence that Mr. Chorney was in fact suffering from any such condition to trigger such self-disclosure. In the circumstances, the Panel was not prepared to find that Mr. Chorney had breached this provision of the Practice Direction.

VII.3 Conduct Unbecoming a Member

224. The CIC requested that the Panel find Mr. Chorney guilty of conduct unbecoming a member.

225. In *Re Seniuk*, a December 12, 2024 decision of a College Inquiry Committee Panel, the panel noted that “conduct unbecoming” arises out of acts performed by a professional in their personal or private capacity. For that behaviour to rise to the level of conduct unbecoming, it must tend to bring discredit upon their profession.

226. Here, the Panel is of the view that Mr. Chorney’s conduct was connected to acts performed (or neglected) in connection with his professional status and would not constitute conduct unbecoming a member.

VII.4 Ungovernability

227. On the basis of Mr. Chorney’s failure to cooperate with the investigation, the prosecution sought a finding that he was and is ungovernable.

228. The Panel was of the view that any such finding would be based on the evidence that has already been adduced at the hearing and is not a determination to be made at the penalty phase of these proceedings.

229. In the CIC’s filed authorities on this point, it raised *Kuny v College of Registered Nurses of Manitoba*, 2017 MBCA 111 [*Kuny*]. In *Kuny*, the Court stated that a finding of ungovernability is based on a case-by-case analysis in which the guiding principle is the public interest. Members of a profession must be willing to be governed by their regulator; otherwise, the public cannot be protected. A demonstrated inability or unwillingness to abide by the decision of a regulatory body will support a finding of ungovernable conduct. The Court upheld the tribunal’s finding of

ungovernability in that case based on the evidence that Mr. Kuny, by his actions and words, refused to accept the authority or take direction from his governing body.

230. Another case that provides general principles for a finding of ungovernability is *Law Society of Upper Canada v. Thomas Michel Hicks*, 2005 ONLSHP 2 [*Hicks*]. *Hicks* holds that a finding of ungovernability requires a factual analysis done on a case-by-case basis where the guiding principle is the public interest. The decision-maker in *Hicks*, at paras 45-46, found that the essence of ungovernability was that the member had shown themselves to be unable and unwilling to be governed by the Law Society, such that the Law Society was unable to fulfill its mandate. When a member is ungovernable, no amount of supervision can make them governable.

231. Beyond these general principles, regulatory bodies have relied on enumerated factors to structure their decisions on ungovernability. In *Hall (Re)*, [2007 LSBC 26](#) [*Hall*], at paragraph 27, the following factors are listed:

- (a) a consistent and repetitive failure to respond to the governing body;
- (b) an element of neglect of duties and obligations to the governing body;
- (c) an element of misleading behaviour directed to a client and or the governing body;
- (d) a failure or refusal to attend at the discipline hearing;
- (e) a discipline history;
- (f) a history of breaches of undertakings; and
- (g) a record or history of practising while under suspension.

232. It is of interest that *Hall*, at paragraph 24, refers to a Manitoba decision - *Law Society of Manitoba v. Ward*, [1996] L.S.D.D. No. 119 where a Panel of three Benchers considered the behaviour of the lawyer in his failure to file an annual Trust Account Report and his repeated failure to respond to communications from the Law Society. The Panel noted the previous record of Mr. Ward with the Law Society that included convictions for similar failures to respond, failures to file Trust Account Reports and a series of fines, all of which remained unpaid, and suspensions. The Panel noted:

... there is a pattern of conduct which is well established in this case; a pattern of conduct which appears to have begun when Mr. Ward failed to file his annual accountant's report, Form D ... That pattern of conduct has continued and has involved breaches of the rules of the Society for two consecutive years for failing to file the Form D. It has involved breaches of the rules of the Society in respect of failing to respond to the Society's communications on a persistent basis. It has involved a failure to pay fines, costs, penalties and annual fees for ... something in excess of a year now. It has involved failures and acts of omission primarily. These have been persistent, inexplicable, and unfortunately from our point of view, unexplained.

In our view, the right to practice law carries with it obligations to the Society and to its members. The minimum obligations in our view are, compliance with rules and

communication with the Society as might reasonably be expected. ... The justification for self government is at least partly based on the assumption that the Society will in fact govern its members and that its members will accept governance. Ward has demonstrated through his behaviour that he does not accept governance.

We regard this as a serious matter. We regard this as a cumulative ongoing set of behaviours and patterns which demonstrate that the member refuses to be governed. Ward cannot say that he is not aware that he was required to respond. Me [sic] should be taken to be aware of the rules. He has been served repeatedly with correspondence and documents requiring him to respond.

As a result of all of this we have concluded that Mr. Ward is in fact, as submitted by counsel for the Society, an ungovernable member...

233. The factors enumerated in *Hall* have implicitly been used in Manitoba. In *Ahluwalia v. College of Physicians and Surgeons (Man)*, 2017 MBCA 15 [*Ahluwalia*], the Manitoba Court of Appeal upheld a decision of the Inquiry Panel of the College of Physicians and Surgeons of Manitoba in which a member was found to be ungovernable based on three of the factors enumerated in the *Hall* test - the seriousness of the conduct, misleading behaviour towards the governing body, and disciplinary history. In finding the member ungovernable in *Ahluwalia*, the Inquiry Panel considered:

- (a) that the member “engaged in several different types of serious misconduct involving multiple written and oral misrepresentations to the College”;
- (b) that the member’s misrepresentations indicated that he was prepared to lie to avoid the governing body’s regulatory jurisdiction, showing he would not respond truthfully to the governing bodies’ inquiries or maintain their required standards in the future; and
- (c) that he had committed similar transgressions in the 1990s, which indicated to the Panel that he had a lack of insight into the seriousness of his misconduct and the importance of adhering to professional standards.

234. The Panel has made a finding that Mr. Chorney failed to cooperate with the College’s investigation. This is a factor to be considered when a regulatory body is seeking a finding of ungovernability. However, while a complete lack of cooperation in an investigation can lead to a finding of ungovernability, it is often only one of several factors that are examined. Other factors that militate towards a finding of ungovernability are a refusal to attend disciplinary proceedings, non-payment of fees, practicing during a suspension, and breaching undertakings previously provided to the regulatory body - all of which indicate an intention not to be governed.

235. *Hall* states however, at paragraph 28, that not all factors need to be present for a regulatory body to make a finding of ungovernability. The indications or factors will have a fact-specific impact in each separate case under consideration. To paraphrase, a finding of ungovernability can

be made if all that was present was a repeated failure of the registrant to respond to inquiries from their regulator provided that failure is illustrative of a “wanton disregard and disrespect” of the registrant for the regulatory processes that govern their conduct.

236. The Panel in this case carefully considered whether Mr. Chorney demonstrated a “wanton disregard and disrespect” for the College and whether his misconduct rose to a level which justified a finding of ungovernability.

237. Although Mr. Chorney’s behaviour with respect to the investigation was inappropriate, and his communications with the College were deficient and occasionally hostile, he has no previous disciplinary history, no record of breaching undertakings, and attended and fully participated in the Inquiry Panel proceedings.

238. In light of the applicable case law and the evidence at the hearing, the Panel concluded that Mr. Chorney’s misconduct fell short of the level that would justify a finding of ungovernability and the Panel is therefore not prepared to find him ungovernable.


VIII. Disposition

239. The Panel will decide on penalty following oral submissions by the parties on November 7, 2025.

Dated at Winnipeg, Manitoba this 14th day of October, 2025.


Signed by:


C446AA3052BE46A...
Michael Foote (Chair/Public Representative)

Signed by:

A151AE98B4C24F7...
Julie Braaksma (Member)

Signed by:

8D20F7F276EB458...
Deanna Douglas (Public Representative)

Signed by:

0E34CCA94FC5416...
Amy Hancox (Member)

Signed by:

AC36F85C23C3423...
Cory Parrott (Member)